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IN THE

Supreme Court of the United States

OCTOBER TERM, 1974

No. 74-1274

ABBOTT LABORATORIES, *et al.*, *Petitioners*

v.

PORTLAND RETAIL DRUGGISTS ASSOCIATION, INC., *Respondent*

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

JOINT BRIEF AMICUS CURIAE OF THE AMERICAN PHARMACEUTICAL ASSOCIATION AND THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

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By consent of the petitioners and the respondent the American Pharmaceutical Association and the National Association of Retail Druggists file this brief as *amici curiae.*

PRELIMINARY STATEMENT

The American Pharmaceutical Association and the National Association of Retail Druggists file this joint brief amicus curiae, urging that the December 26, 1974 decision and order of the United States Court of Appeals for the Ninth Circuit be affirmed.

INTEREST OF THE AMICI

The American Pharmaceutical Association (APhA) is a nonprofit, membership corporation organized and existing under the laws of the District of Columbia since 1852. It is the national professional society of pharmacists in the United States, and its membership consists of more than 40,000 practicing pharmacists, pharmaceutical scientists and educators. Additionally, over 12,000 students enrolled in colleges of pharmacy hold student membership in APhA.

APhA member pharmacists practice their profession in a variety of settings. Some are owners of community pharmacies. Others are employed pharmacists in community pharmacies and in both nonprofit and for-profit hospitals. APhA itself has no commercial interest in any pharmacy, nor does it represent the proprietary interests of pharmacist owners of community pharmacies as such.

The APhA and, of course, its members are vitally interested in the public health and welfare as they may be affected by the profession of pharmacy. In that regard, APhA exists for the purposes of rendering assistance in improving, promoting, and safeguarding the public health and welfare by: (1) maintaining an official compendium of drug standards and specifications; (2) promoting the safe use of drugs; (3) fostering and encouraging inter-professional relations; (4) improving the art and science of pharmacy for the general welfare by the dissemination of scientific information relating to drugs; (5) providing a system of education and training in the art of pharmacy; (6) supporting a system of licensure and registration of pharmacists; (7) developing, maintaining and enforcing a code of ethics for pharmacists calculated to safeguard the public; and (8) cooperating with the United States Government to the fullest in conducting research, examinations, investigations, experiments and in disseminating information.

The National Association of Retail Druggists (NARD), is a nonprofit Illinois Corporation, established nearly a century ago, representing the pharmacists/owners of about 35,000 independent retail pharmacies in which approximately 75,000 of the 120,000 pharmacists in this country practice their profession and dispense about sixty to seventy per cent of the nation's out-of-hospital prescription needs. In addition to filling individual prescriptions, many NARD members provide pharmacy service, including drug needs and convalescent aids for nursing homes and small hospitals. Many APhA pharmacists, who are also community pharmacy owners, are also members of NARD.

The independent community pharmacist today is simultaneously a practitioner and a small businessman. NARD and its members, as does APhA and its members, vigorously support the American free enterprise system which provides the only meaningful climate under which a small business man can economically survive, have the opportunity to succeed by his own efforts, and perform an important and essential service to his community.

Both APhA and NARD and the members of each association have a vital interest in assuring the continued widespread availability of pharmaceutical service to the public when and where such service is required. For many persons, the pharmacist is the most readily-accessible health care professional and, in

addition to the generally-recognized drug dispensing services, the pharmacist serves as an initial point of contact or entry for those persons not having a regularized relationship with the health care system or its professional practitioners.

Both APhA and NARD recognize that the realities of pharmacy practice, as that practice has developed uniquely in this country, include various means and agencies through which pharmaceutical service is provided to the public under different social, economic and health care requirements. The only issue in the instant case, however, involves the providing of pharmaceutical service by nonprofit hospitals to ambulatory patients, hospital employees, staff physicians, and their respective families.

Today, pharmaceutical service is provided to noncharity ambulatory patients by both community pharmacies and hospitals. The latter have provided such service primarily only as a post-World War II activity and when so doing are in direct competition with community pharmacies. Your *amici* are dedicated to the preservation of adequate pharmaceutical service to meet public health needs. Both APhA and NARD recognize, however, that this objective will fail if one segment of competing pharmaceutical service providers is economically disadvantaged so that it is eliminated or threatened with elimination.

ARGUMENT

In essence, the Court of Appeals decision distinguishes between those patients who at the time of their treatment are unable to obtain needed prescription drugs other than in and from the hospital (i.e., bed-

ridden "hospitalized" patients and emergency room patients) and those patients or other individuals who are able to obtain needed prescription drugs outside of the hospital (i.e., "ambulatory" patients, hospital employees, staff physicians, and their respective families). It is clear that the Court of Appeals did not seek a "cubbyhole" approach, as characterized by the *amicus* American Hospital Association; rather, it dealt with specific categories of patients and dispensing/sales situations which were presented to it as a result of the course of the litigation in the district court below. The approach taken by the Court of Appeals is both sensible and sound from a legal and a public policy standpoint. While giving full force and effect to the clear language and purpose of the Nonprofit Institutions Act of 1938, 15 U.S.C. § 13c, the court's decision grants equal dignity (as it must) to the Robinson-Patman Act, 15 U.S.C. § 13.

A. The Court of Appeals decision properly applied the Section 13c exemption to nonprofit hospital pharmaceutical functions.

Both the petitioners and *amicus,* American Hospital Association (AHA), insist that the Court of Appeals misconceived the true nature and functions of nonprofit hospitals and, thereby, applied an erroneous test in determining what drugs were for a hospital's "own use". They further contend that the court's resolution of the issue imposes improper burdens and restrictions on hospital functions. The petitioners and AHA would have this Court adopt a rule under which only the hospitals themselves could determine what supplies were "for their own use," such a determination being based solely on the hospitals' self-concept of their nature and function. Whatever may be the nature

and function of nonprofit hospitals, the determination as to what purchases of supplies by such hospitals are "for their own use" must be based on a standard which is less mutable and more capable of practical application. Moreover, it should be clear that the judicial system should not be ousted of its jurisdiction in matters involving statutory interpretation.

The petitioners state: "The Court of Appeals applied a concept of the nature and functions of hospitals that is inconsistent with the facts of hospital operations and is contrary to the public interest." (Pet. Br. 16) Petitioners argue that the Nonprofit Institutions Act of 1938 was enacted to permit nonprofit hospitals to operate as inexpensively as possible, and, therefore, that any purchases of supplies which are to be used, in the hospital's judgment, as part of the "proper business of a modern hospital" fall within the exemption of that Act. This approach would excise from the Act the key phrase upon which the instant controversy centers.

The Act does permit hospitals to purchase supplies as inexpensively as possible, but only when the hospitals purchase such supplies for "their own use". As the Court of Appeals expressly held:

> "We may concede that in these respects distribution by the hospitals can be justified as a proper and useful community service and thus can be regarded as a proper hospital function. It is not, however, the hospitals' 'own use.'" *Portland Retail Druggists Association, Inc.* v. *Abbott Laboratories, et al.*, 510 F.2d 486, 489 (9th Cir. 1974).

Petitioners place great reliance on the decision in *Logan Lanes, Inc.* v. *Brunswick Corporation*, 378 F.2d

212 (9th Cir.), *cert. denied*, 389 U.S. 898 (1967) as supporting the theory that any purchases made pursuant to a "proper function" are purchases "for their own use." In that case, however, no *supplies* were being *resold* in competition with other sellers of similar supplies.

If a hospital maintains a staff conference room furnished and decorated with materials purchased under the Section 13c exemption, there could be no dispute that the materials had been purchased for the hospital's "own use." If the hospital also occasionally rents the room to unrelated groups and organizations for the holding of conferences and meetings by those groups, such activities and use would not deprive the initial sale of the furnishings and decorations of the coverage of Section 13c under the *Logan Lanes* standard. The maintenance of a staff conference room by a hospital is clearly a proper hospital function, and purchases of the furnishings and decorations would be for the hospital's "own use".

It is also a proper hospital function to purchase sick room supplies (*e.g.*, hospital beds, wheelchairs, bandages, etc.) and to furnish these supplies to bedridden "hospitalized" patients and to emergency room patients. This would clearly constitute the hospital's "own use" of the supplies under the Section 13c exemption. When the hospital decides, however, that the concept of its nature and "proper function" includes selling such supplies to departing patients, hospital employees and staff physicians for *their* use and the use of their families, would such "retailing" of sick room supplies constitute the hospital's "own use"? Surely not.

Extending the petitioners' approach even further leads to the conclusion that nonprofit hospitals may sell all manner of medical supplies and equipment to any member of the public the hospital sees fit to nominate a "patient". Such resales should be justified as the nonprofit hospital's "own use", petitioners and AHA urge, due to the ever-broadening self-concept of a hospital's "proper function" in the "ongoing expansion of outpatient and ambulatory services." In the instant case the Court of Appeals properly limited the hospitals' "own use" as required by Section 13c and made it clear that it is a matter for the courts, and not for the hospitals, to determine the parameters of "own use".

B. Hospitals have not been forced to perform the drug dispensing functions in issue.

Petitioners and the AHA note in their briefs the broad expansion of hospital ambulatory care services which has occurred since the end of World War II. They suggest that nonprofit hospitals have been forced to expand such services including drug dispensing to outpatients. In fact, this expansion of services by hospitals has been both voluntary and aggressive. At the outset, post-war expansion of hospital services, particularly those relating to outpatients, may have been thrust upon the hospitals by health care service shortages elsewhere. There exists substantial evidence, however, that hospitals have elected to turn unwanted adversity into a much sought-after advantage.

Rather than focusing on means to alleviate demand on hospitals for outpatient services, hospitals have chosen to increase the availability of such services to meet the demand. Moreover, there is clear evidence

that, in many instances, hospitals have sought to create a market for outpatient services rather than assist in resolving arguable shortages in ambulatory care services from other sources.

In March, 1968, the AHA convened a conference on "Outpatient Health Care." The report and recommendations of this conference published in 1969[1] reveal hospital objectives relating to out-patient services and outline the means by which those objectives are to be attained.

The preamble of the report and recommendations opens with the following statement of "fact" which sets the tone for all that follows:

> "Hospitals individually and collectively have evolved as the principle community locus where substantial health resources are congregated, either physically or organizationally. The general hospital stands today as the logical organization through which to develop a system for the provision of comprehensive health care for the total community." (p. 3)

That basic axiom is amplified in the same preamble by these observations:

> "Hospitals were organized originally to provide inpatient care. Today, in the light of changes that have taken place in medical practice in the delivery of health care, it is imperative that equal consideration be given to outpatient services."
>
> *"Conferees agreed that the hospital of the future should become an ambulatory care center with inpatient beds attached, rather than a concentration*

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[1] AMERICAN HOSPITAL ASSOCIATION, OUTPATIENT HEALTH CARE (1969).

> ***of beds with outpatient facilities attached.*** The core of the hospital may remain intensive inpatient care, but its major service to the community should be ambulatory care. . . . ***Such a role may involve the hospital in operating satellite units of various types.***" [Emphasis added]

In a list of several "premises" seen by AHA as justification for the expansion of hospital outpatient services, there is found an interesting observation concerning the future availability of health care services for ambulatory patients:

> "As in the past, the majority of patients will receive much of their outpatient care in the offices of their private physicians. However, an increasing proportion of patients will require the use of expensive diagnostic and treatment facilities, usually centralized in hospitals. This will reinforce the desirability of locating physicians offices in or adjacent to the hospital, or in a physical grouping capable of supporting satisfactory diagnostic and treatment services, utilizing the full potential of modern automated techniques." (p. 7)

Thus, recognizing that hospitals would not likely supplant the private office practice of individual physicians, a rationale is presented for drawing such physicians (and their patients) more directly within the influence and control of the hospital. Paradoxically, the AHA desire that hospitals create centralized hospital-physician complexes can only be expected to exacerbate another problem "premise" noted as follows by AHA:

> "For the foreseeable future, there will be limited resources available to provide health care. And, as is often true in a free society, the problems of

> scarce health resources are likely to be compounded by maldistribution." (p. 8)

The essence of the AHA rationale justifying the expansion of hospital ambulatory care facilities and services neatly serves the interests of those hospitals AHA represents and may be summarized as follows: 1) A major inadequacy of the existing health care system is maldistribution of health care facilities and personnel; 2) The existing health care system is inadequate to meet public requirements for ambulatory care and there is a lack of reasonably accessible health care services for patients; 3) Hospitals must "take up the slack" in the existing health care system by increasing ambulatory care services in a centralized facility and/or by creating "satellite" ambulatory care centers.

Under such a strategy, of course, "the general hospital . . . as the logical organization through which to develop a system for the provision of comprehensive health care for the total community" becomes a self-fulfilling prophecy. AHA would create a health care system in which patients will be drawn to centralized hospital facilities either by expansion of ambulatory care services at such facilities or by drawing physicians into closer physical contact with such facilities. Those patients who may not be drawn to centralized facilities can be captured through the simple device of establishing "satellite" facilities which are readily accessible to patients. In the case of ambulatory care pharmaceutical services, at least, community pharmacies are unable to compete with the nonprofit hospital because of the significant economic advantages available to the hospital drug purchases made under the Section 13c exemption.

It might be expected that the expansion services urged for hospitals in 1969 would be an impossible burden on hospital capital and operating budgets, in light of the representations on behalf of hospitals found in the legislative history of the 1938 Nonprofit Institution Act. However, the answer to this dilemma is also found in the AHA report and recommendations on outpatient health care:

> "In the foreseeable future, health insurance programs will be expanded and new methods of providing and broadening coverage for outpatient care will be devised. As a result, almost all patients—be they outpatients, inpatients, or homepatients—will have their care paid for by some third party, public or private, or will pay directly for medical care services. *The 'charity patient' is disappearing.*" (p. 7) [Emphasis added.]

The fact that certain charitable burdens of "nonprofit" hospitals are being eliminated bears directly and substantially on the issue before this Court. While petitioners and the AHA place great emphasis and reliance upon the obvious congressional purpose underlying the Section 13c exemption, that of assisting "charitable" hospitals to serve the "needy sick," it is now readily apparent, as noted by the AHA itself, that within a relatively short period of time, if not already, the "needy sick" will have evaporated as an economic factor in hospital operation. The fact is, that since enactment in 1965 of the Medicare and Medicaid programs, the "needy sick" rationale for the Section 13c exemption has been virtually eliminated.

C. Hospital dispensing of drugs purchased under the Section 13c exemption to ambulatory care patients has had a significant adverse economic impact on community pharmacies.

Available data demonstrate that, since the end of World War II, hospitals have made incredible inroads in the "ambulatory care market." They have done so, in the case of pharmaceutical service, at the expense of community pharmacies.

The argument of your *amici* should not be construed as suggesting that the efforts of hospitals to increase the scope and volume of their ambulatory care services are improper. Such services, in the words of the Court of Appeals, may well be deemed "proper hospital functions". The issue in this case is not whether hospitals are to be permitted to compete with community pharmacies in dispensing drugs, but whether they are to be permitted to compete with an economic advantage which threatens to destroy competition rather than preserve it. As illustrated in Table I of the appendix, evidence exists that this economic advantage held by hospitals has already had a significant adverse impact on community pharmacy practice.

As initially stated, the interest of your *amici* is that of maintaining adequate, readily accessible pharmaceutical service for patients through the preservation of community pharmacies and community pharmacy practitioners as a competitive force in the marketplace. The rationale of the Robinson-Patman Act demands the preservation of this competitive force and prohibits the concentration of the ambulatory care pharmaceutical service in hospitals by means of an unfair advantage.

In its brief, respondent, Portland Retail Druggists Association, sets forth extensive data demonstrating the

destructive effects on competition by nonprofit hospital ambulatory care pharmaceutical service fostered by discriminatory prices granted hospitals in the Portland, Oregon area by petitioners. Your *amici* would supplement this localized information with data providing a broader national view.

In 1962, a total of 3,346 nongovernmental, nonprofit hospitals reported a total of 45.9 million hospital outpatient visits. In 1974, 3,577 such hospitals reported a total of 132.9 million hospital outpatient visits—an increase in just over 10 years of 189.5%.[2]

Total revenues attributable to outpatient services in 1974 for nongovernmental, nonprofit hospitals amounted to $2,823,387,000, or an approximate $789,000.00 per hospital.

While these figures convey the enormity of the increase in hospital outpatient visits during the past 10 to 15 years, they do not illustrate the effect of such increases in the pharmaceutical service area specifically. To assist this Court in its evaluation of this impact, your *amici* urge analysis of the data summarized below and presented in tabular form in Table I of the appendix.

In 1948, the National Association of Boards of Pharmacy (NABP), whose membership includes all state pharmacy licensing agencies, reported the existence of 46,932 community pharmacies, but only 1,221 pharmacies located in hospitals. By 1973, these figures had risen to 50,602 and 5,174 respectively. These figures indicated that while the number of hospital pharmacies had increased over this 25-year period by

[2] American Hospital Association, 1974 Hospital statistics, Tables 1 and 3.

323.8%, community pharmacies had only increased 7.8%. And, this 7.8% increase is misleading.

By 1962, according to NABP, community pharmacies had increased from 1948 levels to 48,841, while hospital pharmacies had increased in that period to 2,911. Hospital pharmacies had, therefore, increased between 1948 and 1962 at a rate of more than five times that of the rate of increase of community pharmacies. However, of greatest significance is the fact that in the period 1962-1973, community pharmacies decreased by 8,239 (−14.0%) while hospital pharmacies increased by 2,263 (177.7%).[3]

While community pharmacy and hospital pharmacy population data are indicators of the competitive impact of hospital outpatient pharmaceutical services, the most direct comparison can be made on the basis of data comparing prescriptions dispensed by community pharmacies versus prescriptions dispensed by hospital outpatient services.

In 1962, hospitals dispensed a total of 53.2 million outpatient prescriptions while community pharmacies dispensed a total of 702.0 million prescriptions.[4] By 1962, therefore, hospitals had acquired 7% of the ambulatory patient pharmaceutical service market. By 1970, the latest year for which such data are available, community pharmacy dispensing had increased to 1.07 billion prescriptions while hospital outpatient dispensing had increased to 149.0 million prescriptions. Thus, in less than 10 years, hospitals had acquired 12.2% of the entire ambulatory care pharmaceutical service market, an increase of 180.1% over 1962, while community

[3] NABP data is for all hospitals. *See* Table 1 of the appendix.

[4] *American Druggist*, June 6, 1966 and August 8, 1971. Hospital data are for all hospitals.

pharmacies prescription volume had increased at a rate of only 52.4%.

While the total number of ambulatory care prescriptions had increased during the period 1962-1970, in large part due to enactment in 1965 of the Medicare and Medicaid programs and the increase in pharmaceutical service "fringe" benefits for many employee groups, the clear trend evidenced by this data shows that hospitals have made substantial gains in their objective of expanding outpatient pharmaceutical service as one component of total hospital ambulatory care services.

Your *amici* suggest that dramatic increases in hospital outpatient dispensing and concomitant decreases in the number of existing community pharmacies are largely attributable to the preferential pricing practices which petitioners and AHA seek to defend as legitimate under the Section 13c exemption. Such a "cause and effect" relationship is suggested by data relating to pharmaceutical services in small (less than 100 beds) hospitals in the period 1962 to 1974.[5]

In 1962, only 4.4% of 6-24 bed nongovernmental, nonprofit hospitals reported operated a pharmacy. For hospitals with 25-49 beds the figure was 19.0%, and less than half (43.6%) of those hospitals having 50-99 beds operated a pharmacy in that year. Thus, only 22.3% of all hospitals having fewer than 100 beds had their own pharmacies as late as 1962.

By 1974, there had occurred a striking change in the small hospital pharmacy service picture. Thus, almost three-fourths (73.4%) of such hospitals reported were operating their own pharmacies in 1974. For those

[5] *See* Table II of the appendix.

hospitals having from 6-24 beds, the figure had risen from 4.4% in 1962 to 57.7% in 1974. Hospitals having 25-49 beds increased their percentages to 72.2% from 19%, and hospitals with 50-99 beds more than doubled their percentages figure from 43.6% to 90.4% during this period. As indicated previously, during this same general time period the number of community pharmacies declined by 14.0% .

While no data is known to exist illustrating the exact nature of the communities in which 8,239 community pharmacies failed during the period 1962 to 1973, it can be observed that "small" hospitals are generally found in "smaller" communities. In communities having hospitals of less than 100 beds, the number of community pharmacies is extremely limited, frequently one or two and seldom in excess of five or six. Although the typical small-town community pharmacy also must engage in the sale of general merchandise to remain economically viable, the professional practice of pharmacy is the base upon which its continued existence depends.

"Smaller" communities are frequently rural and serve populations which are proximate to both the community pharmacy and the hospital or populations which must travel to the community from outlying areas. In either case, pharmaceutical service from both a community pharmacy and the hospital is readily accessible and location becomes relatively unimportant for such patients. In such communities, it would be expected that hospital outpatient dispensing based on preferential prices would have a more severe impact on community pharmacy services than would occur in metropolitan areas. In the latter situation, the adverse impact would be expected to fall primarily on community pharmacies in close proximity to hospitals dispensing to ambulatory care patients.

In smaller communities particularly, the ability of hospitals to control the pharmaceutical service market for ambulatory care patients is more than just a possibility. Your *amici* have been the recipients of numerous complaints from their members in smaller communities regarding the "unfair" competition of hospitals dispensing to ambulatory care patients with the economic advantage derived from the preferential pricing practices of petitioners and other pharmaceutical manufacturers relying on the Section 13c exemption.

D. This Court must reject the "primary purpose" test advanced by AHA.

The *amicus* AHA urges this court to reject the Court of Appeals' approach to the specific limited issues before it in the instant case and to promulgate rather a broad "primary purpose" test to determine the applicability of the Section 13c exemption. Under the primary purpose test constructed by AHA, the nonprofit hospital would be the sole determiner of the breadth of the exemption and would effectively oust the courts of jurisdiction to exercise their own judgments. Thus, the AHA argues (AHA brief pages 24, 25) that the hospital should be permitted complete freedom to determine what are proper functions for it to perform and that purchases made in connection with whatever functions selected should be equated with purchases for the hospitals "own use" within the meaning of the Section 13c exemption.

Thus, if one accepts this argument, one concedes to nonprofit hospitals the right to decide that proper hospital functions include the operation of hospital "satellite" pharmacies next door to and in direct competition with community pharmacies with the drugs

dispensed by the satellite hospital pharmacy subject to the Section 13c exempion. Such a situation would have to be accepted by the courts, because according to the AHA argument, the hospital had concluded by and for itself that such drug distribution was "a proper hospital function." Your *amici* respectfully suggest that this result of the primary purpose test urged by AHA as thus applied is a patent absurdity and clearly outside the beneficent purpose of Congress when it enacted the Nonprofit Institution Act.

CONCLUSION

Your *amici,* the American Pharmaceutical Association and the National Association of Retail Druggists, fully endorse and support the arguments advanced by respondent urging affirmance. The decision of the court below is sound and fundamentally correct in limiting a nonprofit hospital's dispensing of drugs purchased at a discount to conform to the clear intent of Section 13c while at the same time giving proper effect to the purposes of the Robinson-Patman Act and helping to assure the continued viability of the community pharmacy as a valuable community asset. Your *amici* also respectfully urge affirmance of the court below.

Respectfully submitted,

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APPENDIX

APPENDIX

Table 1

Comparative Growth Data: Hospital Pharmacies v. Community Pharmacies

	Community Pharmacies	Hospital Pharmacies	% NGNP Hospitals w/Pharmacies
Number as of 1/1/48	46,932	1,221	
Number as of 1/1/62	58,841	2,911	60%
% Change '48-'62	+25.4%	+138.4%	
Number as of 1/1/73	50,602	5,174	89.8%
% Change '48-'73	+7.8%	+323.8%	
% Change '62-'73	—14%	+177.7%	
Prescriptions'* '62	702,016,000	NG 21,742,000 All 53,200,000	
Prescriptions * '70	1,070,194,000	NG No data All 148,999,000	
% Change '62-'70	+52.5%	NG — All +180.1%	

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* "Prescriptions" for hospitals=sales to *out*patients.

NG=Non-government.

NGNP=Non-government nonprofit.

The above data were collected from the following sources: NATIONAL ASSOCIATION OF PHARMACY PROCEEDINGS 1963; NATIONAL ASSOCIATION OF BOARDS OF PHARMACY, PROCEEDINGS 1974; AMERICAN DRUGGIST (June 6, 1966); AMERICAN DRUGGIST (Aug. 9, 1971).

Table II

Growth Data: Percentage of Hospitals Having Pharmacies

Type of Hospital	Total Number	Total No. W/Pharmacy	% With Pharmacy
1962—All NGNP	3,290	1,975	60.0%
1974—All NGNP	3,434	3,124	91.0
By No. of Beds			
'62 NGNP (6-24 beds)	203	9	4.4
'74 NGNP	104	60	57.7
'62 NGNP (25-49 beds)	643	122	19.0
'74 NGNP	424	306	72.2
'62 NGNP (50-99 beds)	835	364	43.6
'74 NGNP	674	609	90.4
'62 NGNP (100-199 beds)	764	648	84.8
'74 NGNP	826	810	98.1
'62 NGNP (200-299 beds)	445	432	97.1
'74 NGNP	515	514	99.8
'62 NGNP (300-399 beds)	227	227	100.0
'74 NGNP	312	311	99.7
'62 NGNP (400-499 beds)	92	92	100.0
'74 NGNP	185	185	100.0
'62 NGNP (500+ beds)	81	81	100.0
'74 NGNP	212	211	99.5

NGNP=Non-government nonprofit.

The above data were collected from the following sources: AMERICAN HOSPITAL ASSOCIATION, 1974 HOSPITAL STATISTICS, Table 3 and Table 12A.